September 10 September 26 October 8 November 12
December 2 December 10

NEW JERSEY

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

20 West State Street, 10th floor
CN 325
Trenton, NJ 08625

September 10, 1996

Directors Present: J. Donnellan (Prudential); S. Kelly (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Banking and Insurance); R. Rondum; E. Shrem, R. Smart (Mutual of Omaha); G. Young (USHealthcare) (arrived at 10:00 a.m.) L. Yourman

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director

I. Call to Order

J. Donnellan called the meeting to order at 9:50 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call. A quorum was present.

II. Review of Minutes

L. Moskowitz observed that the TAC recommendation concerning the Loss Ratio Calculation did not address how any 2 year period would run, nor did it address the starting date for the change to the 2 year calculation. He also asked if TAC had considered the impact such a change might have on the Access program. He asked that TAC consider these questions and make a recommendation.

L. Moskowitz requested clarification of the data on the 1995 IHC Program Carrier Reimbursement sheet which was attached to the draft minutes. Which number identifies the losses incurred during 1995 - $79,626.239 or $49,218,538? How much is assessed to the industry - $79,626,239 or $49,218,538? He suggested that both figures are relevant and should be shared, explaining that $79,626,239 is the total market loss and $49,218,538 is the amount payable by carriers subject to the assessment that did not seek reimbursement.

R. Smart said that the assessments to carriers were based on the $79,626.239 amount, and was therefore a significant number to report.

L. Moskowitz suggested that since BCBSNJ has such a large share of the market, the losses column and the balance due column on the spreadsheet are not close. Since BCBSNJ had filed to be an exempt carrier for 1996 he speculated that the losses column and the balance due column for 1996 would be closer figures.

R. Smart said she perceived the Program as doing two things: what she termed a "Blues Bailout"; and individual health reform.

L. Moskowitz said that people who are looking at the program focus on the $79,626.239 loss amount, and he believed they should also be advised of the balance due amount.

R. Rondum expressed concern that the IHC Program was still unknown to 16 people who live in her building. She further said she knew someone who called the 800 number for a Guide 30 days ago, and still had not received the Guide. L. Moskowitz responded that there has been a considerable amount of press on the IHC Program and was surprised that these 16 people would not have seen any of it. The Board agreed to continue discussion of marketing issues during the Marketing Committee report.

S. Kelly offered a motion to adopt the minutes of the open session of the August 12, 1996 Board meeting, as amended. L. Moskowitz seconded the motion. The Board voted in favor of adopting the minutes, as amended.

III. Report of the Policy Forms Committee

Grace Period (HMO)
S. Kelly suggested that the optional text should say the person *will* be responsible for the payment of charges incurred for services or supplies received during the grace period. The Board considered the suggestion and decided to retain the permissive verb *may* since it would be the provider that would determine if payment is expected, not the carrier.

L. Moskowitz asked if there was law that would support the ability of a person to pay a premium after the grace period, if the reason premium was not paid was incapacity. The Board agreed a carrier would have to accept late premium in the event of incapacity.

R. Rondum said she was concerned with introducing an option for HMO carriers in the operation of the grace period. She favors fewer options, not adding options.

In light of the optional text added to the grace period provision, the Committee will need to look at the text of the termination provision to make sure a corresponding option is allowed in the termination provision.

Continuity

R. Smart said the Committee recommended that the current policy provision which allows a 30 day "gap" for purposes of pre-existing condition credit be retained. She noted that 30 days was based on the statute. She further commented that a number of other states use a period of 30 days in continuity provisions. L. Moskowitz said that while the law uses 30 days, the Board could determine that 30 days is not adequate, and the Board could liberalize the period.

M. Smyth responded that the law is very specific in using 12 *months* and 30 *days*. Thus both months and days are specified. She noted that a specific number of days, such as 30, is not subject to interpretation, as a period of a month might be.

R. Rondum commented that there are 7 months in which a consumer is in jeopardy because of a 31 day month. L. Moskowitz said the Board could liberalize the 30 days to 31 days whenever a prior month has 31 days.

The Board recognized that the 30 day period may be further complicated if a carrier only accepts 1st or 15th of the month effective dates.

In response to an inquiry regarding consumer complaints, E. DeRosa stated that she has not received calls from consumers who were subjected to a pre-existing conditions exclusion because of a 31 day month. She further stated that the callers typically contact her before switching coverage and she thus has the opportunity to explain the 30 day period before a problem occurs.

R. Smart offered a motion to leave the continuity period as 30 days. S. Kelly seconded the motion. Four Board members voted in favor of the change, three members opposed it (R. Rondum, L. Yourman and E. Shrem) and one abstained (L. Moskowitz). Since an affirmative vote of five Board members is necessary to carry a motion to revise the standard policy forms, this motion did not carry. However, since the motion was to leave the continuity period unchanged, the result was the same, i.e. the continuity period will remain 30 days.

Therapy Services

R. Smart reminded the Board that the Committee was asked to recommend a clarification to the text of the therapy services provision with respect to the 30 visits permitted for physical, occupational, cognitive rehabilitation and speech therapy since the existing language was unclear regarding the application of the 30 visit internal limit. She noted that carriers seem to allow 30 visits for each of these therapies. The Committee reviewed the therapy services benefit in the SEH forms and R. Smart said she recalled that the IHC Board considered using that language but apparently decided against combining various therapies for the purpose of applying a 30 visit limit, as evidenced by the fact that the SEH language was not proposed for the IHC forms. L. Moskowitz expressed surprise that the IHC plans would be more liberal than the SEH plans with respect to therapy services.

L. Yourman commented that during the last meeting she had asked about services available for persons with disabilities or birth defects. R. Smart said the Alternate Treatment provision would allow a carrier to cover more therapy services than 30, and noted that it was a carrier option to extend coverage. J. Donnellan said carriers have the flexibility to use case management. S. Kelly noted that alternate treatment assumes the treatment the carriers offers to cover would be an alternative to some other treatment that would otherwise be covered under the plan. She said the alternate treatment would generally result in a cost savings to the carrier.

R. Smart concluded the discussion of therapy services by saying that the Committee recommended language that would clearly state that these 4 therapies are each subject to a 30 visit limit. Other therapy services are not subject to an internal limit, although infusion therapy does require pre-approval.

Application

The revised document includes a space for an applicant to request an effective date. Since some carriers require that the effective date be the 1st or 15th of the month, for example, the Board asked that the form allow a carrier to add something such as "must be the _____ or _____ of the month"

R. Rondum noticed that the application requests income information and asked if this data was provided to the actuaries. She would be concerned if the information would impact rate setting. S. Kelly said she believed the data was not always completed on the application. K. O'Leary said the information was reported to the Board on the annual enrollment report. It was generally agreed that income information on an application would not be used to set rates. The Board is interested in the data for statistical purposes.

The Board agreed to allow carriers the option to use the "other coverage" form as part of the standard application.

After much discussion concerning how the pre-existing conditions statement should be presented to the applicant, the Board concluded that the carrier's use of the statement would be optional and that if a carrier elected to use the statement it could either make it part of the application or could use it as a separate document. In either case, the carrier would have to use the language provided by the Board. The carrier could explain that failure to complete the statement may result in a delay in the processing of claims. The Board noted that carriers retain the ability to seek additional information at the point of claim, if necessary.

[Break 12:00 - 12:10]

L. Moskowitz offered a motion that the Board provide a standard "pre-existing conditions statement" piece which would be used at the carrier's option, as either part of the application or as a separate document. Completion of the form would be optional to the applicant. Under no circumstance could the form be used as the basis for denying coverage to an applicant. G. Young seconded the motion. The Board voted in favor of the motion, with one abstention (R. Rondum)

Child Only Coverage

R. Smart asked if the Board favored adding the 5th rating tier for children only. G. Young asked if the Board was being pushed to add the 5th tier. L. Moskowitz said the Administration was interested in beginning the Children First program in the near future. He suggested that the Board could make the use of a 5th tier optional to carriers. Further, he said the carriers could elect to construct the rate on either a per child basis or on an composite basis. In order to participate in the Child program, a carrier would have to have a 5th tier. Since carriers would sell the IHC plans in the Children market, the carrier would have to use the same 5th tier for all IHC business. L. Moskowitz said he believed the Program could be operational by January 1, 1997 for marketing. Thus, the first effective dates would occur in March or April. He noted that for the Child program, the rates would have to be uniformly per child or composite.

The Board agreed to do what it could to accommodate the Child Program. To this end, TAC was asked to look at rating issues and Policy Forms was asked to look at the language that was proposed.

L. Yourman asked who the policyholder is in situations of child coverage. R. Smart said the policyholder would be the applicant.

M. Smyth suggested that the Department of Banking and Insurance should put the comments offered during the Board meeting in writing, including the recent focus of the Administration. The comments would give the Board a base on which to make changes to the proposal.

L. Moskowitz summarized that he understands the Board is still committed to supporting the Child Program.

Plan A Clarification

The Board discussed their understanding that the January 1996 changes regarding routine footcare and non-prescription supplies were not intended to expand coverage under Plan A beyond any coverage that may be provided for these services and supplies while hospitalized. The language in Plan A should be appropriately modified.

Agreement

R. Smart said the Committee did not expect the Board to vote to propose the language discussed during this meeting. Rather, the Committee only expected that the Board would reach an agreement on the issues. That agreement was reached.

Timing and Other Considerations

R. Smart commented that some of the issues under consideration as cost reduction measures may result in the need for additional policy forms changes. She asked if the Board preferred that the Committee prepare a proposal to address all the changes the Committee has discussed thus far, or wait until the design issues can be included. She said the Board could release a Bulletin as an interim measure to address the clarification issues. She said her recommendation would be to present all changes as a package.

L. Moskowitz said the Department of Banking and Insurance was about to propose changes which would have to be coordinated with other state agencies and possibly the Governor's Office. He suspected he would be in a position to share the Department's positions with the Board in a week or two.

E. DeRosa was asked to put together a summary of the cost reduction strategies recommended by TAC.

[G. Young left the meeting]

K. O'Leary stated that MSAs are specifically permitted under the Kennedy Kassebaum bill. L. Moskowitz said the Board could include an MSA plan design in the proposal. He noted that the changes needed to accommodate the Child program could be accomplished independently of other changes.

R. Smart observed that the Board could not look to a January 1, 1997 implementation of changes, given the time it takes for a proposal, hearing, and providing ample time for carriers to implement forms changes. The Board agreed to plan for a March 1, 1997 effective date.

R. Rondum asked if the policy forms proposal would address the age rating suggestion she heard discussed during the Summit and recommended by TAC. L. Moskowitz said the Commissioner is in favor of age rating. However, some of the changes under consideration require legislative change, and the age rating is such an issue. Other changes can be accomplished solely by regulatory changes.

M. Smyth commented that there may be internal disagreement among Board members and suggested that before a package of legislative recommendations is presented as Board supported, the Board should vote on the various recommendations.

L. Moskowitz said the Department will make its regulatory recommendations and the Board can accept or reject.

L. Yourman again raised the question of what would happen to the Access Plan D, $250 deductible if the Board votes to eliminate the $250 deductible option. The Board suggested Access could use the $500 option.

K. O'Leary advised C. Nicholas that public relations will be a big part of all the changes.

The Committee was asked to put together a proposal, including all forms modifications agreed upon thus far.

IV. Report of the Executive Director

Expense Report

R. Rondum asked that the payment to Allen Reese be shown on the report

L. Moskowitz offered a motion to approve the payment of the expenses noted on the Expense Report. L. Yourman seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses noted on the September 10, 1996 Expense Report, with R. Smart abstaining with respect to payment to Mutual of Omaha, and E. Shrem abstaining with respect to her reimbursement.

1995 Assessment and Loss Payments

The Board has collected about 98% of the assessment. National Health is the outstanding carrier. Negotiations for a consent order between the Department of Banking and Insurance and National Health have not been completed, which may be contributing to the delay.

K. O'Leary said the 90% payment of losses was wire transferred to the carriers that sought reimbursement.

Appeals

North American Life Assurance Company
The appeal was timely filed, but inadvertently not resolved with the previously considered appeals. The carrier failed to file an exhibit K on a timely basis, so the assessment was based on annual statement premium. The carrier has now filed an exhibit K and requested that the assessment be based on the lower amount of health benefit plan premium.

S. Kelly offered a motion to grant the North American Life Assurance Company appeal. R. Smart seconded the motion. The Board voted unanimously in favor of granting the appeal.

Audit Status

K. O'Leary distributed an update from D&T regarding the status of the 1995 reimbursable loss audits. The report included a breakdown of hours, as the Board requested. L. Moskowitz would like D&T to advise as to percent completion.

The board received a bill from D&T dated 8/28/96.

L. Yourman offered a motion to approve the payment of the 8/28/96 bill from D&T if D&T provides a projection of completion. L. Moskowitz seconded the motion. The Board voted unanimously in favor of the motion.

1993 and 1994 Audits

S. Kelly said BCBSNJ reluctantly agreed to the arrangement the Board proposed during the August Board meeting. Thus, the Board would split the difference between the bid amount and the billed amount with D&T, with BCBSNJ contributing to the payment only through the assessment mechanism. In return, BCBSNJ agreed not to sue on the payment of additional money. K. O'Leary said the Board needs an agreement from D&T that they will accept the reduced payment. The Board discussed what to do if D&T agreed to split the difference between the billed amount and the contract maximum amount.

L. Moskowitz offered a motion that if D&T agrees to the arrangement, the Board should pay half the difference between the bid amount and the billed amount. L. Yourman seconded the motion. The Board voted unanimously in favor of approving the motion.

One Life Group Study

K. O'Leary said he circulated the study to the Board for comments. He reminded the Board that it was an SEH study that was to be done in conjunction with the IHC Board.

Summit Update

L. Moskowitz said the Department's position reflects input received during the summit.

Outreach

8/15/96 WWFN radio
9/17/96 South Jersey Underwriters

K. O'Leary said he was invited to speak in Washington at the Partnership for Prevention.

1994 Reimbursement Request

E. DeRosa explained that Greater Atlantic Health Plan had submitted a request for reimbursement with respect to 1994 losses. Since the Company had not filed an Exhibit Q (Certification of Compliance) indicating it had in fact issued standard plans in 1994, K. O'Leary requested a certification from the company as to the plans that were issued that sustained losses. Such a certification was provided and it indicated the plans were standard plans. To verify the nature of the plans, however, E. DeRosa requested copies of documentation from case files. A review of the material indicated that the company had not issued the standard HMO plan. She advised T. Smith who requested data concerning the number of plans issued. Representatives of Qual Med (Greater Atlantic underwent a name change) met with E. DeRosa to facilitate coming into compliance. The company agreed to discontinue selling new business until all contract forms and applications were revised and a Certification of Compliance submitted.

Since the company violated IHC regulations by not issuing the standard plans during 1994, it was the recommendation of staff that the company be denied reimbursement for losses incurred during 1994.

S. Kelly offered a motion that the Board deny reimbursement of losses incurred during 1994 to Greater Atlantic Health Plan. L. Yourman seconded the motion. The Board voted unanimously in favor of denying the reimbursement of 1994 losses to Greater Atlantic Health Plan.

V. Report of TAC

J. Donnellan discussed the rate filing recommendations shown on the attached TAC Report.

R. Smart offered a motion to accept the TAC recommendations of completeness and incompleteness shown on the September 10, 1996 TAC Report. S. Kelly seconded the motion, The Board voted unanimously in favor of accepting the TAC recommendations, with S. Kelly abstaining with respect to the BCBSNJ and Medigroup filings and J. Donnellan abstaining with respect to the Prudential filing.

J. Donnellan suggested that the Board defer discussion of the manner in which a PPO or POS plan is identified until a later meeting.

VI. Harvard Brandeis Study

R. Smart said the interview process began with Access customers. Letters were being sent out on a staggered basis, so the study team would be able to contact the covered persons shortly after the letters went out. Carrier interviews were scheduled to begin the week of September 16, 1996. Some of the carrier interviews would be conducted in person and others would be conducted by phone. Data from the study should be available early in 1997.

VII. Report of the Marketing Committee

E. Shrem reported that the Committee reviewed the Good Faith Marketing Reports of 4 carriers: CIGNA, NYLCare, Principal and Prudential. The Committee requested

additional information from all of these carriers. E. Shrem reported the Committee expected to be in a position to recommend action on the Reports during the October Board meeting.

E. Shrem said that the Committee recommended the Board "print" a limited supply of the new Buyer's Guide. It would be a photocopy job to provide current information to consumers.

The Committee has been working on a posting that would be placed in municipal buildings, libraries and the like.

An Open Enrollment release was prepared for inclusion in broker publications. E. Shrem asked if the Board wanted to provide information to the public, such as doing a press release. The Board agreed to a press release. In addition, carriers that participate in the IHC program should be advised as to what the Board is doing to promote the October Open Enrollment Period.

E. Shrem advised the Board that the IHC Board is on the internet. The Marketing Committee would review the information to make sure it is current.

K. O'Leary said the SEH Board had investigated a yellow pages ad. They uncovered an ad already in place for the Department. It is possible that the Department's ad may be modified to include information concerning IHC and SEH 800 numbers to secure Buyer's Guides.

L. Yourman asked what happened to the video project. E. Shrem said it was on hold.

S. Kelly observed that the carriers that discontinued marketing new business did not file to request an exemption. Closed blocks of business are likely to incur losses, so she said she would expect some of these carriers to file for reimbursement of losses.

VIII. Report of the Legal Committee

R. Smart said the Committee considered what a carrier that issued pre-reform plans could do if a policyholder asked to add a dependent, or if the policyholder ceased being eligible, but there remained dependents who wanted to continue coverage. The Committee concluded that pre-reform contracts were the jurisdiction of the Department. Contract provisions should govern.

The Committee reviewed a draft withdrawal regulation. S. Kelly asked that TAC have the opportunity to review the withdrawal regulation before the Board acts on it. In addition, the Committee was reviewing the Kennedy Kassebaum bill concerning withdrawal requirements.

R. Smart offered a motion to close the Open Session and begin Executive session. L. Yourman seconded the motion. The Board voted unanimously in favor of beginning Executive Session.

[Executive Session: 2:20 - 3:22 p.m.]

R. Smart offered a motion to: deny BCBSNJ's request for a hearing on the issue of whether the Certifications submitted with the BCBSNJ Exhibits K for

1993 and 1994 validly waived the inclusion of certain expenses inasmuch as the BCBSNJ appeal did not raise any genuine issue of material fact; grant BCBSNJ's request for a hearing with regard to BCBSNJ's challenge of the D & T audit methodology; and ask the Executive Director to issue a final order. E. Shrem seconded the motion. Of the six Board members then present at the meeting, five voted in favor of accepting the recommendation, with one abstention (L. Moskowitz) and one recusal (S. Kelly / BCBSNJ)

IX. Close of Meeting

E. Shrem offered a motion to adjourn the Board Meeting. J. Donnellan seconded the motion. the Board voted unanimously in favor of adjourning the Board meeting. The meeting adjourned at 3:24 p.m.

September 26, 1996

Directors Present: J. Donnellan (Prudential); *S. Kelly* (Blue Cross and Blue Shield of New Jersey); *L. Moskowitz* (Department of Banking and Insurance); R. Rondum; E. Shrem, *R. Smart* (Mutual of Omaha); *G. Young* (USHealthcare); *L. Yourman*
[The names of the Directors who participated by teleconference are shown in *italics*.]

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director

I. Call to Order

J. Donnellan called the meeting to order at 9:50 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call. A quorum was present.

II. Cost Reduction Recommendations

J. Donnellan explained that the purpose of this Board meeting, which was in addition to the regularly scheduled monthly Board meetings, was to consider the Cost Reduction Recommendations he presented on behalf of the TAC during the August 12, 1996 Board Meeting. It was his expectation that the Board would review each of the recommendations, as outlined on the Cost Reduction Recommendations summary provided to Board members,(copy attached to the minutes) and vote on each recommendation.

A. Benefit Design

1. Eliminate Plan A and Designate Plan B as the Basic Plan

J. Donnellan reported that TAC considered the following:
a) enrollment in Plan A was minimal;
b) Plan A has not proven to be a popular plan;
c) Plan B was generally a better buy than Plan A; and
d) movement of the market to a narrower range of plans would likely decrease adverse selection.

L. Moskowitz asked if TAC had given consideration to what should occur with existing Plan A policies. J. Donnellan said TAC discussed giving existing Policyholders "X" period of time to retain Plan A. At the end of that period, Policyholders who wished to be covered would have to convert to another plan. L. Moskowitz suggested that some carriers may not want to force a conversion and asked if those carriers could elect to retain existing Plan A policies as a frozen block of business. S. Kelly said that while marketing persons may not seem eager to force a conversion, from an actuarial perspective, it would be desirable to terminate the business as opposed to retaining a frozen block where the experience would probably deteriorate.

L. Moskowitz asked how the experience on Plan A looked. S. Kelly responded that she believed the experience of BCBSNJ with Plan A policies had been fairly good. L. Moskowitz expressed concern that there may be an outcry from persons who selected Plan A and wanted to retain it.

R. Rondum commented that there were roughly 1300 Plan A policies covering about 4,000 lives. Those persons were sold a plan that was described as guaranteed renewable. She asked how they would be notified that their plans would be discontinued and wondered whether the carriers would be permitted to develop their own notice language or the Board would formulate the language. L. Moskowitz said there should be direct communication from the carriers, and that the Board should not get involved with direct communication to the Policyholders.

S. Kelly said that TAC had discussed requiring carriers to give at least 60 days advance notice of Plan A termination.

R. Rondum said that the Plan A customers purchased the plan in good faith and she expressed concern that they could be disadvantaged by the elimination of the Plan. G. Young asked which Plan a terminated Plan A Policyholder might transition to. S. Kelly said that she had done a comparison of Plan A rates to Plan B rates, and in most instances, a Plan B with a $1000 deductible was less expensive, so Plan B with a $1000 deductible would be a better buy.

J. Donnellan said that once the Board proposes and adopts a regulation governing withdrawals, any carrier that wanted to terminate existing Plan A business could apply to withdraw the Plan. He suggested there may not be extreme harm in allowing a carrier to continue Plan A policies as a frozen block if the carrier elected not to withdraw the Plan.

L. Moskowitz suggested that maybe the concern with terminating existing policies would be reduced if a longer period of time would be given before existing Plan A policies would be terminated.

S. Kelly speculated that rate volatility might occur if Plan A were retained indefinitely. L. Moskowitz said that eliminating Plan A seemed to be the best answer, but that public relations would have to be handled with care.

R. Rondum asked if anyone had discussed the prospect of eliminating Plan A with Senator Cody, who had been a sponsor of the "bare bones" law on which Plan A was originally based. L. Moskowitz said that Marc Buro could arrange to meet with Senate staff to discuss terminating Plan A.

L. Moskowitz asked if legislation would be needed to eliminate Plan A. J. Donnellan said that the Board could eliminate Plan A by regulation and no legislation would be required.

E. Shrem offered a motion that existing Plan A policies be frozen indefinitely.

S. Kelly said she preferred freezing the block for a maximum of one year. At the point of termination, the customers would be given a special open enrollment period, allowing them to buy up to purchase any other Plan, as already occurs during the annual October Open Enrollment Period. Thus, these terminated Policyholders would have the opportunity to "buy up" during 2 open enrollment periods.

E. Shrem said customers should not be locked into specific open enrollment periods. If the Plan the person purchased was being terminated, the person should be free, at any time, to purchase any other Plan.

L. Moskowitz said there should be a date certain for ceasing the sale of new Plan A policies. That date could be 30 days after the Board's regulation would be adopted, which was expected to be March 1, 1997. The termination of existing Plan A policies could be 12 months following the cessation of new business.

L. Moskowitz replaced the motion that led to the above discussion with a new motion. L. Moskowitz offered a motion that: carriers cease marketing Plan A to new customers 30 days after the Board's regulation to eliminate Plan A is adopted; existing Plan A policies continue until 12 months after that date; and Plan A customers given an additional Open Enrollment Period to be described by regulation. R. Smart seconded the motion. The Board voted in favor of the motion, with one abstention (R. Rondum)

[R. Rondum explained that she abstained for the following reasons: she felt she had been called to this unusual meeting to discuss recommendations whose implementation had not been carefully considered; and there had been no courtesy of notification given to Senator Cody, the sponsor of the "bare bones" legislation.

E. Shrem asked that termination notices be required to be sent via certified mail.

Details concerning the open enrollment period should be set forth in regulations.

Staff was asked to begin working on the proposal that would eliminate Plan A.

2. Modifications to Plan B

Maximum Lifetime Benefit

J. Donnellan said that TAC recommended that the current $1,000,000 lifetime maximum benefit be increased to an unlimited lifetime maximum benefit, as exists in the other standard Plans. He said there was minimal cost associated with the increase to an unlimited maximum.

L. Moskowitz expressed concern with eliminating the $1,000,000 lifetime benefit feature as he believed the lifetime maximum feature differentiated Plan B from Plan C. E. DeRosa commented that Plan B contains the hospital confinement copayment feature which does not exist in Plan C.

E. Shrem offered a motion that the Board propose a modification to the lifetime maximum benefit in Plan B to increase such benefit from $1,000,000 to an unlimited lifetime benefit. L. Yourman seconded the motion. The Board voted unanimously in favor of increasing the lifetime maximum benefit in Plan B from $1,000,000 to unlimited.

Eliminate Plan B $250 and $500 Deductible Options / Discussion of MSA Option

J. Donnellan explained that low deductible options have produced the greatest rate volatility and adverse selection.

L. Moskowitz said that the same procedures discussed for the elimination of Plan A should apply to the elimination of these deductible options. J. Donnellan agreed.

S. Kelly said in the IHC Program, there were 112 people with Plan B $250 deductible and 324 people with Plan B $500 deductible. She explained that there were too many variances in rating with 3 deductible options. The addition of a $2500 deductible option (which was the next item on the list of recommendations) was thought to have been consistent with an MSA plan design and TAC recognized the fact that a $2500 deductible would reduce the cost of the Plan. K. O'Leary said that the MSA plan design contained in the Kennedy / Kassebaum bill would not be compatible with cost reduction plans, as discussed by the Board.

E. Shrem said that her clients want a catastrophic plan.

R. Rondum asked if there had been any discussion of a plan that would allow the Board's plans to qualify as part of a target group for the MSA plans. L. Moskowitz asked if the Board believed it needed to have a plan that would qualify as an MSA plan under the Kennedy / Kassebaum bill. The Board said yes. Under the legislation, tax deductibility of MSA contributions begins as of January 1, 1997.

S. Kelly said the addition of a $2500 deductible option to Plan B was intended to address affordability issues, not tax deductibility. J. Donnellan said TAC attempted to satisfy the public outcry for a high deductible plan.

R. Smart offered a motion that the Board be ready at the October Board meeting to propose an MSA eligible plan. L. Moskowitz seconded the motion. The Board voted unanimously in favor of developing an MSA plan to be ready for proposal at the October Board meeting.

L. Moskowitz offered a motion that the Board propose a modification to Plan B to eliminate the $250 and $500 deductible options.
L. Yourman expressed concern with eliminating the $500 option. L. Moskowitz commented that the same termination rules that would apply to the elimination of Plan A would apply to the elimination of these two deductible options.
R. Smart seconded the motion. The Board voted unanimously in favor of proposing a modification to Plan B to eliminate the $250 and $500 deductible options.

[Note: Subsequent discussion amended this motion. Refer to the <u>Eliminate the $250 Deductible Option Under Plans C and D and the $150 deductible Option Under Plan E</u>
section of these minutes, on page 6.]

<u>Add $2500 Deductible Option to Plan B</u>

J. Donnellan said TAC viewed the $2500 option as a catastrophic option for customers. He further said TAC believed it wise to experiment with a high deductible on only one plan before making any recommendations as to the value of such an option for other plans. If added to other plans without the benefit of analysis of this experiment, it may exacerbate rate volatility.

J. Donnellan noted that the increase in the deductible would not affect the coinsurance cap since the deductible was in addition to the coinsurance cap. [Note: Plan B has a $3000 coinsurance cap per person / $6000 per family]

E. Shrem offered a motion that the Board propose a modification to Plan B to add a $2500 deductible option. L. Yourman seconded the motion. the Board voted unanimously in favor of proposing a modification to Plan B to add a $2500 deductible option.
[Note: Subsequent discussion amended this motion. Refer to the motion at the end of Eliminate the $250 Deductible Option Under Plans C and D and the $150 deductible Option Under Plan E section of these minutes, on page 7.]

Eliminate the $250 Deductible Option Under Plans C and D and the $150 deductible Option Under Plan E

K. O'Leary asked how many persons were covered under these deductible options. S. Kelly said that under Plans C $250 deductible there were 45 persons, 76 if the POS option was included; under Plan D $250 deductible there were 438 persons, 1150 if the POS option was included; and under Plan E $150 deductible, 34 persons.

L. Moskowitz offered a motion that the Board propose to modify Plans C, D and E to eliminate the $250 deductible option under Plans C and D and the $150 deductible option under Plan E. R. Smart seconded the motion. The Board voted in favor of the proposed elimination of the $250 and $150 deductible options with L. Yourman opposed the motion with respect to the $250 deductible options with Plan D to the extent this option was available to the health access customers.

L. Moskowitz said there were only about 50 persons in Health Access covered under a Plan D $250 deductible.

L. Yourman said she had suggested to L. Moskowitz that it would be cheaper for the Health Access program to subsidize a Plan D $1000 deductible plan. She thought there could perhaps be a Policyholder rebate with respect to the difference between the $250 and $1000 deductible options.

E. Shrem said she believed there should be a higher deductible under Plans C and D. She commented that under the proposal, a customer would be forced to purchase a Plan B in order to secure a high deductible plan. J. Donnellan said that adding a high deductible to these plans might further adverse selection and create rate volatility. E. Shrem responded that healthy people have no opportunity to get a good plan with a high deductible.

J. Donnellan asked her to consider the total marketplace. The people who want the $2500 option were those who can afford $2500 out of pocket. There would be an negative impact as a result of adverse selection on the $500 and $1000 options.

E. Shrem reported that prior to reform she commonly sold a $2500 deductible plan. J. Donnellan asked if the plans were guaranteed issue. E. Shrem said they were pre-reform plans and were medically underwritten. J. Donnellan said TAC tried to formulate recommendations that would somewhat create a balance in the rating.

L. Moskowitz asked if a $500 and $1500 selection would work. The Board was not comfortable with that option since a large number of persons were covered under the current $1000 deductible option.

S. Kelly said there were 865 persons with Plan C $500 deductible.

E. Shrem suggested that the Board eliminate the $500 deductible option under Plan C, keep the $1000 deductible option and add a $2000 or $2500 deductible option. S. Kelly observed that this would create two high deductible plans plus the Kennedy / Kassebaum plans with high deductibles.

L. Moskowitz suggested that the Board could use Plan C as the high deductible option test plan rather than Plan B. Plan B would retain the current $500 and $1000 deductible options.

E. Shrem offered a motion that the Board propose modifications: to Plan B to eliminate the $250 deductible [Plan B retains $500 and $1000 deductible options]; to Plan C to eliminate the $250 and $500 deductible options, keep the $1000 deductible option and add a $2500 deductible option; to Plan D to eliminate the $250 deductible option; and to Plan E to eliminate the $150 deductible option, with the Board seeking an actuarial input on the effect of these changes. L. Yourman seconded the motion. The Board voted unanimously in favor of the motion.

[Note: The prior vote concerning the increase in the lifetime maximum benefit under Plan B remains unchanged.]

B. Loss Ratio Calculation

J. Donnellan said TAC recommended that the loss ratio be calculated over a 2 year period as opposed to the current one year period. TAC also recommended that there be minor modifications to the refund formula to more closely resemble the refund formula used in SEH regulations. L. Moskowitz agreed with the recommendation, commenting that it would be expected to produce greater rate stability.

S. Kelly offered a motion that the Board recommend that the loss ratio calculation be made over a 2 year period and that the refund formula more closely track the SEH refund formula. L. Moskowitz seconded the motion. The Board voted unanimously in favor of the motion.

[Note: This modification requires legislation.]

C. Rating

J. Donnellan said that TAC recommends a movement to modified community rating, based only on the factor of age, with a 2:1 rate banding.

E. Shrem said she was not opposed to modified community rating, but was opposed to the 2:1 band. She said she had done some calculations as to the impact on customers of various ages, and the impact on the 60+ population would be significant. A copy of E. Shrem's worksheet, which illustrates the examples she offered, is attached. She expressed concern with such an increase for the 60+ population and suggested a tighter rate band, 1.5:1. E. Shrem asked that the Board review the statistics on the ages of persons who have purchased IHC Plans.

R. Rondum commented that the Board should consider the persons who have not purchased coverage and those who have dropped coverage. R. Rondum noted that there had been no significant study on age banding. She said she was very concerned with the impact age rating would have on the 50 - 64 year old population. R. Rondum said statistics show that in the last half of 1995, the 45 - 54 age group experienced the highest percentage of unemployment since 1991. She suggested that the peak in purchasing of IHC Plans by older individuals may well have been caused by job loss. R. Rondum further said that the Board should consider income data. An increase in rates for the 50 - 64 population would likely result in displacement of these policyholders due to cost considerations. R. Rondum said she had not seen any data that suggested that age banding was sound public policy.

L. Yourman commented that the under 30 population tends to be transient and may not retain coverage for an extended period. The older population was more stable, yet the movement to age rating would drive them away.

R. Rondum said the way to stabilize cost would be to get the 800,000 who have no coverage to buy coverage. She characterized the IHC program as a "stealth program," noting that she had never seen a half page ad in a newspaper to get the word out about the Program. She researched the cost for a half page ad in a Sunday edition, and it would only cost $2200. She asked what was the urgency with moving to age rating at this time.

R. Rondum said the June 17, 1996 TAC minutes reflected the committee's initial discussion concerning the possibility of a recommendation to move to modified community rating. On that same day, a BNA newsletter was released which quoted K. O'Leary as saying the Summit may lead to modified community rating. R. Rondum continued that in the middle of the Summit, the Commissioner of Banking and Insurance stood up and spoke in favor of modified community rating. The Board first heard about the Summit discussions during the July 9, 1996 Board meeting. R. Rondum said it appeared there had been some behind the scenes maneuvering: The Board did not know what K. O'Leary spoke of in a June 17, 1996 publication until July 9, 1996. Since the June 17 publication had to have been written some time prior to June 17, K. O'Leary would have commented to a reporter concerning modified community rating prior to June 17.

L. Moskowitz said legislation had been introduced that would have moved away from community rating in ways that would have destroyed the program. During the last several months, there have been attempts made to preserve the Program. R. Rondum asked why the Board had not been informed. K. O'Leary reported he had

been part of meetings with Department of Banking and Insurance staff since April, and the Commissioner had taken part in those meetings. The Commissioner convened the Summit. He said he believed the notice had mentioned the possibility of a change to community rating.

R. Rondum asked why the Board wasn't notified.

S. Kelly said TAC was not in a position to make recommendations concerning a move to modified community rating until after it completed some actuarial research. TAC was thus not in a position to present a firm recommendation until the August Board meeting.

R. Rondum commented that the process made her feel uneasy. She believed the Board should have been given preliminary glimpse of possible changes to be considered during the Summit. She asked if non carrier Board members knew what was going on. J. Donnellan said that the Commissioner had the authority to convene a Summit and invite the public at large.

R. Rondum said that the Board was not on the same level as members of the Governor's cabinet. Something as significant as a move from pure community rating should have been brought to the Board, especially to the public members who did not have ready access to information as did the carriers.

L. Moskowitz said that he thought some of the proposed bills that surfaced had been distributed to Board members. He said the Commissioner had responded to proposed rate structures that seemed out of line. He said the Commissioner had a responsibility to provide a position, on behalf of the Administration.

R. Rondum said an unspoken premise of reform was universal access. She views this process as one which will devastate New Jersey's leadership role in health insurance reform. She noted that the process began when the SEH Program moved away from pure community rating, then allowed non-standard plans, and now there was a threat to the IHC Program's use of pure community rating.

L. Moskowitz said there was a need to review the current program. Was the Program doing what was right or what was wrong?

L. Yourman observed that when the Board sends material to carriers for comment, the Board receives little response. She wants to know why the carriers don't reply and aren't more interested. She asked for more study on community rating. Maybe the Board should look at geographic location, or smoker vs. non-smoker rating. Maybe the changes the Board already agreed upon would be sufficient. She asked that the Board wait to see what happens as a result of the agreed upon changes.

R. Rondum offered a motion that the Board table any further discussion on a change from pure community rating to modified community rating until more study had been done. L. Yourman seconded the motion. [Restated: There would be no recommendation on a movement to modified community rating pending further study; delay any rating action until the Board can review the impact from the policy design changes.]
The Board voted to oppose the motion by roll call vote, 5 opposed; 3 in favor:
5 opposed: J. Donnellan, R. Smart, L. Moskowitz, G. Young, S. Kelly

3 in favor: R. Rondum, L. Yourman, E. Shrem

L. Moskowitz offered a motion to accept the recommendation of TAC and ask that modified community rating, based on age, subject to a 2:1 band be proposed to the Commissioner as a statutory amendment. The 2:1 band would only apply to persons age 20 and older. The child only tier would not be considered in the 2:1 band, nor would the child tier be considered part of the single person tier.
The Board voted in favor of the motion by roll call vote, 5 in favor; 3 opposed:
5 in favor: J. Donnellan, R. Smart, L. Moskowitz, G. Young, S. Kelly
3 opposed: R. Rondum, L. Yourman, E. Shrem

In presenting the information to the Commissioner, K. O'Leary will present the majority and the minority opinions. The three Public Board members would like there to be further study before there is a deviation from pure community rating.

R. Rondum said she opposed the motion because of the "urgency" with moving from pure community rating, the impact on reform and lack of adequate information.

K. O'Leary read from the minutes of the June 11, 1996 Board meeting that he announced the Commissioners' convening of a Summit. R. Rondum said that K. O'Leary did not tell the Board that there would be a discussion of community rating as he had shared with the reporter and was printed in a June 17, 1996 publication. K. O'Leary said that he had simply shared with the press a summary of the preliminary discussions leading up to the Summit. J. Donnellan said that K. O'Leary did, in fact, advise the Board of the Summit.

L. Moskowitz offered a motion to adjourn the meeting. S. Kelly seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting adjourned at 12:05 p.m.

October 8, 1996

Directors Present: J. Donnellan (Prudential); J. Fiedler (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Banking and Insurance); R. Rondum; E. Shrem, R. Smart (Mutual of Omaha); L. Yourman

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director

I. Call to Order

J. Donnellan called the meeting to order at 9:40 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. K. O'Leary took roll call. A quorum was present.

II. Review of Minutes

September 10, 1996

L. Moskowitz offered a motion to adopt the minutes of the open session of the September 10, 1996 Board meeting, as amended. R. Smart seconded the motion. The Board voted unanimously in favor of adopting the minutes, as amended, with one abstention, J. Fiedler.

September 26, 1996

R. Smart offered a motion to adopt the minutes of the open session of the September 10, 1996 Board meeting, as amended. L. Moskowitz seconded the motion. The Board voted unanimously in favor of adopting the minutes, as amended, with one abstention, J. Fiedler.

III. Report of the Policy Forms Committee

Child Only Tier
R. Smart reported that it appeared the Board had provided the Policy Forms Committee with direction on all the issues presented thus far, with the exception of the child only rating tier. The mandatory or permissive use of a 5th rating tier needed to be agreed upon before the Policy Forms Committee can prepare a document which includes all changes to the standard plans.

J. Donnellan reported that TAC considered the 5th tier and concluded that there did not appear to be any harm done by allowing carriers to elect to *offer* the 5th tier. However, if a carrier elected to use the 5 tiers, the carrier should be required to offer 5 tiers across all plans. He further reported that TAC believed the basis for a child only tier should be a composite as opposed to a per child rate. The child component for the Parent/Child(ren) tier as well as the Family tier was a composite rate. Thus, in order to be consistent, the child only rate should be a composite rate.

R. Rondum expressed concern that an optional implementation of a 5th tier would create an unlevel playing field.

R. Rondum noted that while the Board had advised her that coverage for a child or child(ren) was currently available under the 4 tier structure, the availability of such coverage has not been made known to consumers. She observed that neither the forms nor the Buyers' Guide specifically stated that child(ren) only coverage could be purchased.

R. Rondum commented that the standard plans identify 5 situations in which a person would be considered a "child", as defined. The child must be: the person's own issue; legally adopted; a stepchild; someone for whom the person has legal custody; or someone for whom the person has guardianship. She further noted that the forms specifically state that a grandchild and a foster child are not a child, as defined. She continued by stating that she would like to see the definition expanded to cover functioning households.

L. Yourman agreed that coverage should be available to an adult and child(ren) in the absence of the child criteria noted above, if the adult had responsibility for the child(ren).

R. Smart returned to her original question: should the use of the 5th rating tier be optional or mandatory. R. Rondum said that a voluntary use of the 5th tier would create an unlevel playing field. Further, she wanted eligibility expanded to allow coverage of an adult and child(ren) under a single policy, whether or not the adult was the parent or legal guardian.

L. Moskowitz summarized by noting the Board had two issues relative to the child only tier: 1) should the use of the 5th tier for children be optional or mandatory; and 2) should the definition of child be expanded.
E. Shrem commented that under current IHC market rules, a carrier had the option to not offer Plan E. [Staff's Note: A carrier that markets the standard HMO plan may elect to offer only A - D, and not offer E. Plan E is considered to be equivalent to the HMO and the carrier thus satisfied the obligation to sell Plan E by selling the HMO plan.]

L. Yourman said that the consumers should have as much selection as possible. If a customer needed to purchase coverage solely for children, and liked a particular carrier's network, but that carrier offered only the 4 tier rate, the customer would be forced to either settle for the network of a carrier that offered the 5th tier, or pay the appropriate rate under the 4 tier structure.

R. Smart noted that the Board had generally favored standardization, but many carriers responded to the Board's survey concerning the child only tier by stating that they were not set up to use a 5th tier. Further, making adjustments for a 5th tier would be at great expense. She feared the program might lose carriers if a 5th tier were mandated.

L. Moskowitz suggested that a composite child(ren) rate might be close to a single rate.

R. Smart offered a motion that the 5th rating tier (Child only tier) be made optional, with the child(ren) rate being a composite rate (to cover one or more children at the same rate). If a carrier elected to use the optional 5th tier, the carrier must offer the 5th rating tier for all standard plans. J. Fiedler seconded the motion. The Board voted unanimously in favor of allowing an optional composite child only rating tier, with one abstention, R. Rondum. R. Rondum explained that she abstained from the vote because the Board separated the issue of the optional or mandatory use of the 5th tier from the issue of the child definition.

The Board reviewed the language differences between the current 4 tier definition of child and the definition of child as proposed in the child only proposal as contained in Board materials. L. Moskowitz asked if there was a reason to use a different definition for child in a 4 tier rating system as opposed to a 5 tier rating system. He suggested that the use of different definitions could create an unlevel playing field. Thus, the Board should consider using a single definition for child, and that definition should be the expanded definition that appears in the proposal for child only coverage.

R. Rondum stated that in addition to using the expanded definition of child, the adult/child tier should be expanded to allow the head of the household to cover himself or herself *plus* the children under a single policy. L. Yourman offered an example of a parent wanting to cover himself or herself plus his or her own children plus a niece that the person was caring for, under a single policy.

R. Smart noted that the Policy Forms Committee intentionally did not use language in the child only proposal that would have allowed a child to be covered under the same policy as an adult who was neither the parent nor the legal guardian.

L. Moskowitz asked that both TAC and the Policy Forms Committee review the matter and be prepared to make a recommendation during the November Board meeting.

[Break: 11:10 - 11:25 p.m.]

New Issues

E. DeRosa explained that the current indemnity plans did not contain any language a mutual carrier would use to explain ***dividends***. The Board agreed there should be a dividends provision, but would like to give the carrier the option to substitute some

other language to describe dividends, as had been filed with the Department of Banking and Insurance by that carrier.

E. DeRosa explained that M. Malloy of the Department of Banking and Insurance advised that the individual forms must contain a ***reinstatement*** provision. The Board asked the Policy forms Committee and M. Smyth to consider the appropriateness of such a provision in the standard plans.

E. DeRosa suggested that a carrier be given the opportunity to implement plan ***modifications to Plan A via rider***. The Board agreed that rider language to accomplish the modifications should be provided to carriers once the modifications have been adopted.

E. DeRosa noted that the standard HMO plan specifically excluded coverage for ***therapeutic manipulation***. She explained that this approach was not consistent with the coverage for 30 visits per year for therapeutic manipulation in Plans B - E, nor was it consistent with the SEH Board's coverage for 30 visits per year for therapeutic manipulation in both the HMO plan and in Plans B - E. J. Fiedler asked that the Board secure some cost data regarding the addition of 30 visits for therapeutic manipulation before voting to amend the HMO form. TAC was asked to provide cost input concerning the cost of adding coverage for 30 therapeutic manipulation visits per year to the HMO contract.

MSA Plan Design

E. DeRosa explained the draft MSA plan design, as contained in Board materials. The draft contemplated a separate document which included only MSA type provisions. An alternative would be to create variable text within the current standard plans.

After some discussion, the Board concluded it preferred the use of variable text within the standard plans. The deductible options should be limited to the lowest and highest possible: $1500 / person and / or $2250 / person.

J. Donnellan asked if the plan options should be limited only to those persons who qualify for an MSA. L. Moskowitz suggested the plan options could be generally available.
E. DeRosa commented that the Board intended to propose a number of changes to the standard plans. Carriers that elected to market MSA plans would therefore prepare policy forms for January, including the MSA provisions. However, later in 1997, the carrier would have to update the plans to include plan modifications. The Board considered the burden to carriers, but decided to propose the MSA text independent of other text modifications, based on the availability of MSAs under Federal Law as of January 1, 1997..

The Board asked M. Smyth and C. McDevitt to review the Kennedy Kassebaum bill for changes that the Board may need to make to the standard plans as of July 1, 1997.

The Board recognized that there was no guarantee that a plan which contains all the apparent elements of an MSA plan would actually qualify as an MSA under the demonstration project.

J. Donnellan offered a motion to propose variable text to Plans C and D which would accommodate an MSA plan design, using only the $1500 and $2250 per person deductible options, with a $3000 per person out of pocket amount, with corresponding family amounts. R. Smart seconded the motion. The Board voted unanimously in favor of proposing variable MSA text, as stated.

The proposal would follow the expedited rule proposal process. the required public hearing was scheduled for the November 12, 1996 Board meeting.

[Break: 12:35 - 12:50]

IV. Report of the Executive Director

Expense Report
E. Shrem explained that the printer that would print the new Buyers' Guides required a check prior to printing the job.

The Board noted the expenses for Capitol Copy and asked if there were another means to have the rate comparison sheets copied. Staff explained that Capitol Copy was conveniently located and performed additional services in compiling and delivering the rate sheets to DEPTCOR. The Board concluded these charges were appropriate.

J. Fiedler offered a motion to authorize the payment of the expenses noted on the October 8, 1996 Expense Report. L. Yourman seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses noted on the October 8, 1996 Expense Report.

Audit
K. O'Leary mentioned the status report prepared by D & T, as contained in Board member materials.

K. O'Leary explained that D & T had not yet responded as to the Board compromise on the bid amount vs. the billed amount for the 1993 and 1994 reimbursable loss audits.

Appeals / Reconciliation

K. O'Leary said all appeals of the 1995 assessment had been decided. He was working on the final orders.

K. O'Leary asked if he should wait for the results of the audit prior to doing the 1995 reconciliation. R. Smart suggested he should ask D & T for an estimate of audit completion. If the audits were expected to be completed by December, it would make sense to wait for the audits before doing the reconciliation.

Summit Update

L. Moskowitz reported that in a week or two, the Commissioner should be prepared to release recommendations. The recommendations would be directed to the Governor's Office, the Legislature, or the Board, as appropriate.

He said the package of recommendations would be made available to the public for comment. He hoped legislation could be proposed and adopted by the end of 1996.

L. Yourman asked why the Board could not be involved with the discussions. L. Moskowitz said that discussions with the Board would be premature and that it would be better to share with the Board only those recommendations that would likely go further. He noted that proposals to the legislature and the Governor's office were the responsibility of the Department of Banking and Insurance, in conjunction with the Department of Health and Senior Services.

L. Yourman observed that there was little consumer representation at the Summit.

L. Yourman asked that the Board extend an invitation to Senators Bateman and Garrett to meet with the Board. L. Moskowitz noted that the Board's normal channel to communicate with the legislature should be to go through the Commissioner. However, if the Board identified an issue of urgency, the Board could go directly to the legislature. Any legislative changes the Board might want to propose should go through the Commissioner.

R. Rondum said she always believed the Board had policy making authority. She said she only learned two weeks ago that there was a "commitment" and as a result, there appeared to be no independence in certain areas. L. Moskowitz said the Commissioner of Banking and Insurance had the authority to introduce and initiate changes in health policy.

L. Yourman said that as a group of persons familiar with the IHC program, the Board should request the opportunity to discuss IHC issues with the Commissioner. K. O'Leary suggested that any discussions might be more effective if members could present a unified voice.

L. Moskowitz said that the September 30, 1996 draft communication to the Commissioner should be expanded to include the Board's desire for communication with the Commissioner, with the possibility of joint discussions with the legislature.

M. Smyth cautioned that a collective Board meeting expressing a Board position may be subject to the Open Public Meetings Act.

J. Donnellan said he as well as one or more consumer members could arrange to meet with the Commissioner. As Chair, he would express the dissenting views as well as the majority views. L. Yourman said she would be comfortable with J. Donnellan plus one consumer member meeting with the Commissioner. J. Fiedler asked if a carrier should be represented. L. Moskowitz said it might be appropriate to invite some SEH Board representatives to join the meeting.

One Life Group Report

K. O'Leary said he released the one life group report to the legislature and the Governor. The conclusion reached in the report was that there should be no change to the current structure of requiring 2 or more employees in order to qualify for group coverage.

Enrollment

K. O'Leary said the second quarter enrollment reports indicated a decline in enrollment as compared to the first quarter reports, from 220, 384 to 204,552. He noted that during the same period, SEH Program enrollment increased. L. Moskowitz commented that a decrease in IHC enrollment coupled with an increase in SEH enrollment was to be desired since it could suggest that the responsibility for coverage was shifting from individual to group.

V. Report of the Technical Advisory Committee

L. Moskowitz offered a motion to accept the recommendations of TAC and deem the rate filings shown on the October 8, 1996 Report of TAC (copy attached) as complete. L. Yourman seconded the motion. The Board voted unanimously in favor of deeming the specified rate filings complete.

J. Donnellan said the Committee had not yet considered how to show rate increases on the TAC report in a meaningful manner.

J. Donnellan said TAC considered the 1994 refund plans for 3 carriers, and was prepared to make recommendations for two such plans. TAC requested additional information from the third carrier (Protective).

L. Moskowitz offered a motion to approve the 1994 refund plans for Metropolitan Life Insurance Company and Travelers Insurance Company. L. Yourman seconded the motion. the Board voted unanimously in favor of approving the specified 1994 refund plans.

VI. Harvard Brandeis Study

R. Smart said she had no new information, but that the study was moving forward.

VII. Report of the Marketing Committee

E. Shrem said the Committee reviewed the Good Faith Marketing Reports of 4 carriers that had filed for a conditional exemption, but enrolled less than 50% of the specified market target. The attached Recommendations of the Marketing Committee summarize the basis on which the following motions were made and votes taken.

R. Smart offered a motion to accept the 1995 Good Faith Marketing Report of CIGNA. L. Yourman seconded the motion. The Board voted unanimously in favor of accepting CIGNA's 1995 Good Faith Marketing Report, and thus granting a final pro-rata exemption.

E. Shrem offered a motion to disapprove the 1995 Good Faith Marketing Report of NLYCare. J. Fiedler seconded the motion. The Board voted unanimously in favor of disapproving NYLCare's 1995 Good Faith Marketing Report, and thus denying a final exemption. [The Company was known as Sanus in 1995]

L. Yourman offered a motion to disapprove the 1995 Good Faith Marketing Report of Principal Mutual Life Insurance Company. J. Fiedler seconded the motion. The Board voted unanimously in favor of disapproving Principal Mutual Life Insurance Company's 1995 Good Faith Marketing Report, and thus denying a final exemption.

E. Shrem offered a motion to accept the 1995 Good Faith Marketing Report of Prudential. L. Moskowitz seconded the motion. The Board voted unanimously in favor of accepting Prudential's 1995 Good Faith Marketing Report, with J. Donnellan abstaining, and thus granting a final pro-rata exemption.

E. Shrem said she distributed the Marcus Group's report to the Board.

L. Yourman offered a motion to authorize printing of the posting (flyer) the Board considered during the September Board meeting, with cost not to exceed $500. R. Rondum seconded the motion. The Board voted unanimously in favor of authorizing the printing of the posting, as specified.

VIII. Executive Session

E. Shrem offered a motion to begin Executive Session. R. Smart seconded the motion. The Board voted unanimously in favor of beginning Executive Session.

[Executive Session: 2:40 - 3:25 p.m.]

IX. Close of Meeting

E. Shrem offered a motion to close the Board Meeting. R. Rondum seconded the motion. The Board voted unanimously in favor of closing the Board meeting. The meeting adjourned at 3:25 p.m.

November 12, 1996

Directors Present: J. Donnellan (Prudential); J. Fiedler (Blue Cross and Blue Shield of New Jersey); R. Rondum; E. Shrem, R. Smart (Mutual of Omaha); R. Vehec (Department of Banking and Insurance)

Others Present: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director, W. Kramer (USHealthcare, but not designated as either the Director or the Alternate representative)

I. Public Hearing

J. Donnellan opened the public hearing at 9:40 a.m. He reminded those in attendance that the purpose of the hearing was to provide comments on the Board's proposed modifications to the standard policy forms, Plans C and D which were intended to accommodate an MSA plan option. The scope of any testimony to be offered was not to extend beyond comments pertinent to the policy forms modifications.

J. Fiedler commented that BCBSNJ questioned the appropriateness of retaining the emergency room copayment feature in the MSA plan design, given the fact that BCBSNJ believed the copay would count toward the out of pocket maximum. He further commented that the IHC Board should consider extending MSA type provisions to schedule pages appropriate for a PPO or POS plan. E. DeRosa noted that the issue J. Fiedler raised with respect to the emergency room copayment would seem to similarly apply to utilization review penalties. She commented that H.R. 3103 did not offer guidance in terms of what charges may be excludable from the calculation of the out of pocket maximum.

There being no additional persons wishing to offer testimony at that time, J. Donnellan suspended the hearing, with the understanding that further testimony would be accepted if a commenter should arrive to provide comments.

II. Call to Order

J. Donnellan called the Board meeting to order at 9:48 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

III. Report of the Policy Forms Committee

R. Smart reported that the Committee had been asked to consider a couple of issues. Since R. Smart was not able to participate, however, R. Rondum chaired the meeting of the Policy Forms Committee. R. Rondum would thus provide the report of the Policy Forms Committee.

R. Rondum described the discussion of the Policy Forms Committee meeting. She said that the Board received comments on the child only tier proposal and that the committee had reviewed the comments as well as the responses prepared by W. Sanders.

Child Only Coverage
R. Rondum reported that E. DeRosa summarized the various stages of policy form language relative to the child only tier. M. Smyth discussed some legal issues concerning coverage for children with the Committee. The Committee then focused on the issue the Board presented concerning the use of different definitions based on the use of a 4 tier or a 5 tier rating structure. R. Rondum reported that the Committee recommended that, with minor modifications, the 5 tier approach to the following definitions would be appropriate:

a) Child
b) Dependent
c) Per Lifetime
d) Policyholder

Since the use of the 5th rating tier would be optional, the Committee concluded the definitions should be consistent.

R. Rondum reported that the Committee discussed coverage for children and an adult who were members of the same household, where the adult was responsible for the support and maintenance of the child(ren), in circumstances where there were blood or legal ties between the adult and child(ren). By majority vote, 4 -2, the Committee recommended that coverage for an adult and child(ren) in such situations should be available under one policy, as opposed to one policy for the adult and another for the child(ren). She explained that the majority voters represented 2 carriers, the Department of Banking and Insurance and a public member. The minority voters represented 2 carriers.

Reinstatement
As had been requested by the Board, the Committee considered whether a reinstatement provision was appropriate in the IHC forms. R. Rondum said the Committee was convinced such a provision was required by statute.

R. Smart asked how the Board wished to vote on the changes. The Board decided to delay voting until the December meeting. R. Smart suggested that since a number of the changes the Board would be proposing were clarifications to the forms, the Board may want to release a bulletin to carriers to advise carriers concerning the administration of the provisions to be clarified.

R. Smart asked what to do with the outstanding child only proposal. She commented that the text, as proposed, was not consistent with text necessary to accommodate the approach and provisions the Board has informally agreed upon during the past several Board meetings. Was there a mechanism to withdraw the proposal? R. Rondum said that she thought that if changes to a proposal would expand the public's rights, re-proposal would not be necessary. M. Smyth agreed to look into the steps that should be taken in order to withdraw the proposal.

I. Public Hearing (Continued)

J. Donnellan asked if anyone present wanted to comment on the proposal. An audience member asked about state tax deductibility of MSA plans. J. Donnellan noted that the question was beyond the scope of the proposal, and not within the jurisdiction of the Board. Another audience member asked how the Board intended to advise employers of the carriers that would be selling MSA plans. K. O'Leary responded that carriers would likely provide notice of the availability of a new plan.

There being no further discussion, J. Donnellan concluded the Hearing at 10:10 a.m.

IV. Report of the Executive Director

Expense Report
K. O'Leary called the Board's attention to the Deloitte & Touche (D&T) expense. He said this represented the second billing for the 1995 reimbursable loss audits, with the total payment approximately $142,000. He reminded the Board that pursuant to the contract, billing for the 1995 reimbursable loss audit was on an hourly basis.

R. Rondum inquired about the status of the additional payment for the 1993 and 1994 reimbursable loss audits. K. O'Leary reported that he sent a letter to D&T and explained the settlement offer the Board adopted, but that he had not yet received a reply.

J. Fiedler offered a motion to approve the payment of the expenses noted on the November 12, 1996 Expense Report. J. Donnellan seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses, with R. Rondum abstaining with respect to reimbursement of her expenses.

Audit

K. O'Leary reported that the audits of Time Insurance Company, National Casualty and BCBSNJ were largely completed. He reported that the Operations Committee met to discuss some issues D&T raised with respect to their audit of BCBSNJ. The Operations Committee was looking into the propriety of reporting as claims amounts that were paid to the Division of Medical Assistance for underpayments to Medicaid eligible policyholders as well as late payment penalties paid at the direction of the Department of Banking and Insurance. The amount in question was approximately $5.2 million with respect to the Medicaid payments and $236,000 with respect to the late interest penalties. J. Donnellan said that the Operations Committee would like both the Legal Committee and the Attorney General's Office to look into the appropriateness of reporting the $5.2 million as claims.

The reimbursement sought by Manhattan National was not as large as other carriers, only $374,000. As a result, D&T advised that a full scale audit may not be needed. Manhattan National has been sent an information request, based on suggestions from D&T. The information was due in mid December. Either D&T or the Operations Committee would examine the data.

J. Donnellan said there was a matter with Time Insurance Company concerning overpayment of some claims and underpayment of others.

K. O'Leary explained that the administrative audit was still being delayed over the treatment of interest. He explained that the interest issue also affects the loss audits since a carrier has claimed lost interest as losses. D&T asked K. O'Leary to provide precise information on interest income. He said he contacted CoreStates and requested exact information on interest. K. O'Leary said S. Sanders offered to assist him with setting up the methodology to record interest income.

1995 Assessment

K. O'Leary reported that all the appeals were completed and the orders written and reviewed by the Attorney General's Office. According to the Regulations, the reconciliation for 1995 was scheduled to occur in December. The reimbursable loss audits have not been completed. Therefore, the reconciliation could only take the appeals into account. K. O'Leary reported that the reconciliation due solely to the appeals would not be significant, while the reconciliation as a result of the audits could have serious consequences. He suggested it may not make sense to do a reconciliation prior to the completion of the audits. M. Smyth suggested that the regulations should be revised to allow adequate time to have all necessary information prior to doing the reconciliation. The Board agreed that K. O'Leary should defer the 1995 reconciliation until the reimbursable loss audits were completed.

M. Smyth asked what the Board would do if all the audits could not be brought to a timely resolution. J. Donnellan suggested that D&T would issue an audit report. At

that time the Board may have to deal with negotiation or litigation. J. Fiedler expressed concern with the effect of a delay of the reconciliation on carriers.

J. Donnellan offered a motion to delay the billing of the 1995 reconciliation at this time, and re-visit the issue on a monthly basis, considering the progress of the audits. R. Smart seconded the motion. The Board voted unanimously in favor of the motion.

Draft Budget
K. O'Leary noted that the difference in budgeted salaries and actual salaries was attributable to the lack of an accountant for which he had budgeted last year. The Department of Banking and Insurance had not yet allowed him to hire an accountant. The Board discussed the urgency of resolving any impediments associated with the hiring of an accountant, given the complexity of the Board's accounting. K. O'Leary said that the accountant would take over all the tasks performed by the bookkeeper the Board had retained, plus a host of financial duties.

E. Shrem expressed concern with the amount allocated to marketing efforts and asked for time to come back to the Board with a more realistic figure.

K. O'Leary said the draft budget was for fiscal 1997 which began July 1, 1996 and concludes June 30, 1997.

Miscellaneous
K. O'Leary said he wrote to Assemblymen Bateman and Garret to invite them to attend a Board meeting, as requested by the Board. He did not receive a reply. He reported he wrote to the Commissioner of Banking and Insurance, also at the Board's request, and requested the opportunity to discuss changes to the IHC Program and had not received a reply. R. Rondum asked to be provided copies of correspondence on a timely basis.

K. O'Leary said D&T recommended that the Board have two accounts, one for administrative expenses and one for loss amounts. K. O'Leary asked for authorization to hold administrative funds in a separate account.

E. Shrem offered a motion that K. O'Leary have a separate account set up to hold administrative funds for the IHC Program. J. Fiedler seconded the motion. The Board voted unanimously in favor of establishing a separate account for administrative funds.

K. O'Leary reported he received a letter from BCBSNJ requesting clarification of some of the provisions in Plan A. A copy was included with the Board materials. He asked the Board how to respond. M. Smyth asked if the letter was connected to litigation as the issues appeared to be admissions / denials. E. Shrem suggested that the Board could send BCBSNJ a copy of Plan A. M. Smyth said the Board could identify the pertinent provisions in Plan A, but cautioned against responding to the letter as "admissions" by the Board.

K. O'Leary said the NAIC was having a meeting on November 22, 1996 during which there would be extensive discussion of the Kennedy Kassebaum bill. He reported that he asked W. Sanders to work on drafting revisions to the IHC and SEH laws to comply with federal Law and asked if the Board would be willing to share the cost of Ward's travel to the meeting with the SEH Board.

E. Shrem offered a motion that the IHC Board pay half the cost for W. Sanders to attend the NAIC meeting.

R. Smart opposed sharing in the cost since she said there was little in the law that affects the IHC Program. K. O'Leary said he was concerned that the Board may miss something and he thought the sessions for regulators would be useful. **E. Shrem withdrew her motion.**

K. O'Leary reported he spoke on WTTH, an Atlantic City radio station on September 22, 1996, and attended a Partnership for Prevention Conference in Washington on September 10, 1996. Copies of letters to the editor he had written were in the Board packets.

The Board considered a tentative meeting schedule for 1997 meetings. M. Smyth suggested that the Annual Meeting be so designated.

E. Shrem offered a motion to accept the draft schedule, as changed. J. Fiedler seconded the motion. The Board voted unanimously in favor of accepting the draft meeting schedule, as modified.

[Break: 11:30 a.m. - 11:40 a.m.]

V. Report of TAC

Rate Filings

R. Smart offered a motion to accept the TAC recommendations on the rate filings shown on the attached Report of the Technical Advisory Committee. R. Vehec seconded the motion. The Board voted unanimously in favor of deeming the rate filings shown on the attached TAC Report complete.

Therapeutic Manipulation Survey

J. Donnellan said the results of the survey to HMO carriers regarding the cost associated with including 30 therapeutic manipulation visits in the HMO plan suggested a slight increase in cost. E. Shrem said the benefit must be added to the HMO plan, noting it was covered in Plans B - E. W. Kramer said he was concerned with doing anything that would increase cost, even if the increase were slight.

E. Shrem offered a motion to add 30 therapeutic manipulation visits to the HMO plan. R. Rondum seconded the motion. The Board voted unanimously in favor of adding 30 therapeutic manipulation visits to the HMO plan.

J. Donnellan noted that it would require PCP authorization, and the provider would have to be in the HMO's network. He also noted that it was always a Board intent to make the benefits in B - E consistent with the HMO, to the extent possible.

CIGNA

J. Donnellan reported that CIGNA relinquished Federal Qualification. TAC would like the Legal Committee to review CIGNA's status pending either receipt of new Federal Qualification or marketing Plans A - E.

VI. Report of Ad Hoc Committee - Harvard Brandeis

R. Smart said she had nothing to report. W. Kramer said the study team had interviewed USHealthcare employees.

VII. Report of the Marketing Committee

E. Shrem reported that 5000 Buyer's Guides had been printed and she asked to print more to last until a new Guide would be needed to coincide with modifications to the standard plans. Upon reprint, the guide would be saddle stitched and would be a self-mailer.

E. Shrem said she would have a committee meeting prior to the December Board meeting and would be prepared to discuss a budget during the December meeting.

VIII. Executive Session

R. Smart offered a motion to begin Executive Session. J. Fiedler seconded the motion. The Board voted unanimously in favor of beginning Executive Session.

[Executive session: 12:05 p.m. - 1:08 p.m.]

IX. Close of Meeting

R. Smart offered a motion to close the Board meeting. E. Shrem seconded the motion. The Board voted unanimously in favor of adjourning the meeting.

[The meeting adjourned at 1:08 p.m.]

December 2, 1996

Directors Participating: J. Donnellan (Prudential); J. Fiedler (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Banking and Insurance); E. Shrem, R. Smart (Mutual of Omaha); G. Young (USHealthcare), L. Yourman

Others Participating: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director, W. Sanders, SEH Program Assistant Director

I. Call to Order

J. Donnellan called the Board meeting to order at 2:35 p.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. He took roll call. A quorum was present.

II. Discussion of MSA Policy Forms Proposal

J. Donnellan explained that this special Board meeting had been called to discuss the MSA policy forms proposal and move for adoption, if the Board was so inclined.

J. Donnellan asked E. DeRosa to review the comments with the Board. All comments were offered by BCBSNJ.

L. Moskowitz asked E. DeRosa to explain how the policy forms changes were accomplished in the proposal. E. DeRosa said that by creating variable text in 3 areas of plans C and D, and carrier could use the standard forms for Plans C and D to accomplish either the existing standard plans or the proposed MSA type plans. Thus, existing text was made variable so it could be deleted in favor of the proposed variable text.

L. Moskowitz asked why the proposal was limited to Plans C and D. E. DeRosa responded that the first draft was more flexible, but the Board requested that the extent of the changes be limited to only 2 deductible options and Plans C and D.

Comment 1
E. DeRosa explained that the emergency room copayment would be considered a covered charge and would therefore seem to apply to the out of pocket maximum. Once the out of pocket maximum had been satisfied, the copay would no longer apply. The commenter suggested that it would be administratively difficult to not collect the copay after the maximum had been reached. Further, the commenter indicated the cost associated with removing the copay would not be significant.

The Board discussed if it might be wise to eliminate the copay from the existing standard plans but concluded it was an important deterrent against using the emergency room unnecessarily.

The Board agreed with the draft response to the comment and the elimination of the emergency room copay from the MSA schedule text.

Comment 2
E. DeRosa explained that while she developed text to accommodate a managed care type plan (PPO and POS), W. Sanders advised her that the Board would have to propose such new text, and it could not be included in the adoption. The Board agreed to pursue the necessary steps to produce a managed care MSA option in the future.

L. Moskowitz asked why IHC carriers were not offering managed care plans. E. Shrem said customers ask for the option. E. DeRosa noted that she receives a fair number of calls from persons who are interested in PPO or POS plans. L. Moskowitz recalled that at the July 1, 1996 Summit which was convened by the Department of Banking and Insurance, some carriers said they were not offering PPO and POS plans because the 25% administrative allowance was not adequate to cover the administrative costs associated with managed care plans.

Comment 3
E. DeRosa noted that the commenter correctly identified the need to modify N.J.A.C. 11:20-3.1 to reflect the new deductible options. W. Sanders added that this section was also clarified to state that the standard plans with the $250, $500 and $1000 deductible options still needed to be offered. The MSA options would be in addition to those required plans. He further noted that the higher deductible options should be able to be sold with or without an MSA. In the statute, eligibility for an IHC plan does not rely on participation in an MSA account.

E. Shrem noted that the Board discussion concerning the elimination of some deductibles and addition of others was not reflected in the regulation. J. Donnellan explained that the changes the Board discussed in September had not been proposed. L. Moskowitz said the proposal on the MSA type changes had moved along quickly in order to be ready for the January 1, 1997 availability of MSA accounts.

Agency Initiated Change
E. DeRosa explained that while considering the impact of the emergency room copay on the out of pocket maximum, she looked into the impact of the utilization review penalties. Since the penalties should not be used to satisfy the out of pocket maximum, such penalty could not be considered a covered charge. In reviewing the definition of a non-covered expense she noted that the utilization review penalty was already identified as a non-covered expense. However, the deductible, copayment and coinsurance were likewise identified as a non-covered expense. While the intent was probably to indicate that benefits would not be payable to the extent a charge was used toward the deductible, a copay or coinsurance, the charges were still covered charges. Thus, E. DeRosa recommended that the definition be changed for the MSA plans as well as all standard plans. L. Moskowitz agreed the charges would be covered charges, but would not be eligible for reimbursement. J. Donnellan cautioned against creating an additional problem. K. O'Leary said the practical result of including the change in the adoption would be that the definition would be fixed for MSA plans. It would have to be fixed later for all other standard plans.

J. Fiedler said that N.J.A.C. 11:20-3.1(d) should be amended to state that the MSA plan options could not be offered as managed care plans at this time. The Board agreed.

G. Young offered a motion to adopt the MSA plan rule proposal, amendments to N.J.A.C. 11:20 Appendix Exhibits C and D and N.J.A.C 11:20-3.1. E. Shrem seconded the motion. By roll call vote the Board voted in favor of the adoption, with 6 votes in favor and 1 abstention (L. Yourman).

J. Donnellan thanked the Board for their willingness to participate in this special meeting.

III. Other Business

R. Smart asked about the upcoming Legal Committee meeting and the request from the Operations Committee to consider whether the reimbursement BCBSNJ paid to Medicaid should be reimbursable. J. Donnellan said that the Operations Committee wanted the Legal Committee to consider whether the payment could be considered as an eligible item for reimbursement. D&T was considering the $5.2 million amount allocated to the individual line of business but wanted legal input as to whether this payment was a "claim."

IV. Close of Meeting

L. Moskowitz offered a motion to adjourn the meeting. E. Shrem seconded the motion. the Board voted unanimously in favor of adjourning the meeting.

[The meeting adjourned at 3:10 p.m.]

December 10, 1996

Directors Participating: J. Donnellan (Prudential); J. Fiedler (Blue Cross and Blue Shield of New Jersey); L. Moskowitz (Department of Banking and Insurance); E. Shrem, R. Rondum; *R. Smart* *(Mutual of Omaha); G. Young (USHealthcare), L. Yourman
** Participated via telephone*

Others Participating: K. O'Leary, Executive Director; DAG M. Smyth (DOL); E. DeRosa, IHC Program Assistant Director

I. Call to Order

J. Donnellan called the Board meeting to order at 9:40 a.m. K. O'Leary announced that notice of the meeting had been published in three New Jersey newspapers and posted at the Department of Banking and Insurance and the Office of the Secretary of State in accordance with the Open Public Meetings Act. A quorum was present.

II. Review of Minutes

November 12, 1996
In response to the Board's inquiry concerning the status of the hiring of an accountant, K. O'Leary explained that he was attempting to have another classified position added by the Department of Personnel to the complement for the IHC and SEH program staff.

J. Fiedler offered a motion to adopt the minutes of the November 12, 1996 Board meeting, as amended. R. Smart seconded the motion. The Board voted in favor of adopting the minutes, as amended, with 3 abstentions. (G. Young, L. Moskowitz, L. Yourman)

December 2, 1996
L. Moskowitz offered a motion to adopt the minutes of the December 2, 1996 Board meeting, as amended. G. Young seconded the motion. The Board voted in favor of adopting the minutes, as amended, with 1 abstention. (R. Rondum)

E. Shrem asked about the timing for proposal and adoption of the high deductible options the Board had considered earlier in the year. The Board agreed that the high deductible options would be part of the package of other changes and that while the package of changes should be ready for proposal in early 1997, implementation may not occur until July 1997.

III. Report of the Policy Forms Committee

Draft Bulletin
Board members were asked to review the draft bulletin (96-IHC-03) and provide written comments to E. DeRosa no later than Monday, December 16, 1996. J. Fiedler asked that a summary of comments and responses be sent to the Board members.

Child Only Coverage
R. Smart directed the Board members to the November 12, 1996 minutes for a summary of the background on the outstanding issue concerning child only coverage.

M. Smyth said that she researched the Board's question concerning how to withdraw the proposal which created a mandatory 5th rating tier for child only coverage, which was published in the May 20, 1996 New Jersey Register. She said withdrawal would be accomplished by sending a notice of withdrawal to the Office of Administrative Law.

R. Smart reminded the Board that while the Board elected to make the use of the 5th rating tier optional, the Board believed there to be merit in using a consistent structure for eligibility, regardless of the use of a 4 tier or a 5 tier rating structure.

R. Rondum said that a person should be able to purchase coverage for himself of herself *and* any child(ren) for whom the person is responsible, under a single policy.

After some discussion as to whether the changes the Board was considering relative to the child only coverage could be implemented as agency initiated changes in an adoption of the May 20, 1996 proposal, M. Smyth reported that the nature of the changes being considered was substantive and the value of the original notice would effectively be destroyed. The Board agreed that the changes to accommodate the child only coverage would be made as part of the larger package of 1997 changes, and that the May 20, 1996 proposal should be withdrawn.

After re-reviewing the November 12, 1996 recommendations from the Policy Forms Committee, both G. Young and J. Fiedler asked for clarification of what the Policy Forms Committee intended in the use of the phrase "tied by blood." E. DeRosa reported that during the Committee's discussion, grandparents and aunts and uncles were offered as examples. J. Fiedler asked that the Board establish specific boundaries. L. Moskowitz observed that any action the IHC Board might take would not affect the SEH Board's standard plans.

R. Smart said she reviewed the draft eligibility language and suggested that items 3 and 4 of the definition of Dependent be clarified to refer to the dependent criteria that already existed in item (a)(2) of the Dependent definition.

L. Yourman offered a motion that the Board revise the definition of a Dependent, and thus expand eligibility, to allow coverage for an adult and a child or children, under a single contract, provided the adult and child(ren) are tied by blood or law. R. Rondum seconded the motion. By majority vote, the Board voted in favor of the motion. (7 in favor, 1 opposed - R. Smart)

L. Moskowitz commented that the child only tier would allow an adult who is eligible for coverage under a group plan to purchase individual coverage for a child or children who did not qualify as dependents under the group plan.

IV. Report of the Executive Director

Expense Report

In addition to the expenses noted on the December 10, 1996 Expense report, K. O'Leary also asked the Board to consider reimbursement to R. Rondum of $94.87, for travel and telephone for November and early December. With respect to the D&T item of $98,172, $80,000 was billing for the 1995 loss audits through October 1996. Thus far, the Program has paid $231,544, and this payment of $80,000 would bring the total for the 1995 loss audits to approximately $310,000. K. O'Leary noted that the carriers being audited were responsible for 50% of the cost of the audit, so the Program would be reimbursed for half the cost. L. Yourman asked that the expensed for D & T be displayed in a separate column on the Expense Report, and not be specified under Miscellaneous.

L. Yourman offered a motion to approve the payment of the expenses shown on the December 10, 1996 expense Report. G. Young seconded the motion. The Board voted unanimously in favor of approving the payment of the expenses, with R. Rondum abstaining with respect to the reimbursement to be paid to her.

1993 - 1994 Reimbursable Loss Audits
K. O'Leary said he followed up with D & T regarding the Board's compromise resolution to the billing for the reimbursable loss audit. S. Sanders verbally said D & T would agree to the Board's proposal, and that D & T would prepare and send a bill.

1995 Reimbursable Loss Audits
There were a couple of open items with the BCBSNJ audit. As discussed during the November meeting, the matter of the payment to the Division of Medical Assistance for Medicaid reimbursement as well as the interest penalties on late payments need to be addressed. The Operations Committee would meet to discuss these two items. K. O'Leary reported he sent a memo to Velvet Miller in November concerning the Medicaid issue, but had not yet received a reply.

The field work for the audits of Time and National Casualty were complete. Both carriers were asked to provide some additional information, and both have responded.

K. O'Leary reminded the Board that since the size of the reimbursement requested by Manhattan National was only $374,000.00, the company had been asked to provide specific data by December 15, 1996. That data would be reviewed by either the Operations Committee or D & T.

1994 - 1995 Administrative Audit
K. O'Leary reported that the administrative audit was still incomplete. The outstanding issues involve reconciling the book balance with the balance that existed in the Board's accounts. He requested a printout of the treasury accounts. The Department was supposed to have been deducting salary and benefits plus overhead from the SEH account, since October 1994. During a meeting on December 6, 1996, K. O'Leary learned that overhead expenses had never been taken from the account. R. Rondum asked if there was a written procedure in place. K. O'Leary said there was.

1995 Reconciliation
As previously discussed, the reimbursable loss audits were still not complete. Therefore, as discussed during the November Board meeting, it made no sense to proceed with the reconciliation.

Budget
E. Shrem asked to double the amount indicated for marketing. She indicated the need to re-do the Buyer's Guide once the plans change, as well as to do new advertising, such as advertorials. J. Fiedler asked to see a business plan before budgeting extra funding. E. Shrem said that until a Marketing Consultant has been designated, the Committee would not be in a position to offer a specific plan. E. Shrem agreed to vote to approve the budget for now, and then come back to the Board later with a business plan. The amount shown for auditing services was the gross amount. The Board's actual responsibility would be 50% of that amount.

Legislative Activity
K. O'Leary said there was a hearing in the Senate Commerce Committee on S 1523 on November 25, 1996. He said he testified, but limited the scope of his testimony to issues such as the effect of the elimination of the assessment mechanism, non-standard plans, and the like. A fact sheet, as included in the Board packets, was the basis for his presentation. The bill had been up for a hearing and a vote, but the vote never occurred, and Senator Cardinale said the Committee would re-visit the bill in a few weeks.

K. O'Leary said that on December 9, 1996, A 2261 was discussed in the Assembly Insurance Committee. That bill included the "guarantee acceptance plan." K. O'Leary said he testified at that hearing as well.

High Deductible Options
K. O'Leary said he prepared a press release concerning the availability of deductible options that could qualify as MSA plans. As a result of that press coverage, the 800 number had been overwhelmed with calls from people asking about MSA plans. K. O'Leary said that Assemblyman Bagger introduced a bill that would give favorable state tax treatment to MSA plans.

L. Moskowitz suggested that a communication be sent to carriers to advise them as to what the Board had done. M. Smyth commented that the Department of Banking and Insurance had a task force working on Kennedy Kassebaum, and that it may make sense to delay any communication in order to produce a joint release that would be sent to the public at large. L. Moskowitz said he believed it the Board's responsibility to keep the public informed.

Outreach
Comcast Newsmakers - Discussed individual and group coverages as well as MSAs.
NJN - Discussed MSAs on the New Jersey Incorporated program.

V. Report of the Technical Advisory Committee

Rate Filings
J. Donnellan said the TAC reviewed 9 rate filings and was prepared to recommend that the Board deem 8 of the filings complete.

L. Moskowitz offered a motion to deem the 8 rate filings shown on the Report of the Technical Advisory Committee (copy attached) complete. L. Yourman seconded the motion. The Board voted in favor of deeming the rate filings complete, with J. Fiedler abstaining with respect to the BCBSNJ filing, and G. Young abstaining with respect to the Aetna filing.

J. Donnellan explained that the 9th filing was a BCBSNJ filing for pre-reform plans. P. Thexton had raised a few questions, such as the duration of the experience period, the source of the trend factors, and the rating differential for the pre-reform plans. J. Donnellan suggested the Board refer the filing back to TAC since BCBSNJ had offered to supplement the filing. BCBSNJ could use the rates contained in the filing since the filings were informational and may thus be used until deemed incomplete. J. Donnellan said TAC may hold a meeting before the end of the year to discuss the BCBSNJ data. The next scheduled TAC meeting would be in early January.

Performance Report Certification
J. Donnellan said that the Certification originally provided by National Casualty was not IHC specific so the TAC requested more specific statements. The response did not offer any more detail concerning IHC. J. Donnellan noted that D & T audited National Casualty. Thus, was there a purpose to pursuing the Certification? E. DeRosa was asked to send D & T all correspondence with National Casualty regarding the Certification. The Board asked the Attorney General's Office to consider if the Board could elect to not pursue the Certification.

VI. Report of the Ad Hoc Committee

R. Smart said she had not had any contact with the Harvard Brandeis team.

R. Rondum asked if the study team could offer a preliminary report by January. R. Smart agreed to present the request.

VII. Executive Session

J. Fiedler offered a motion to close open session and begin executive session. G. Young seconded the motion.

[Executive Session: 11:45 a.m. - 2:09 p.m.]

VIII. Final Business and Close of Meeting

L. Moskowitz offered a motion to approve the proposed budget. G. Young seconded the motion. The Board voted unanimously in favor of approving the proposed budget.

L. Moskowitz offered a motion to adjourn the meeting. J. Fiedler seconded the motion. The Board voted unanimously in favor of adjourning the meeting. The meeting adjourned at 2:10 p.m.